THE IMPACT OF DATA ON EFFECTIVE HEALTH POLICY FORMULATION A CASE STUDY OF THE JIGGER INFESTATION IN BUSOGA REGION.

BY

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2011-B141-10046

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A DISSERTATION SUBMITTED TO THE FACULTY OF SCIENCE IN PARTIAL FULFILLMENT OF THE REQUIRMENT FOR THE AWARD OF THE BARCHELOR OF SCIENCE OF UGANDA MARTYRS' UNIVERSITY NKOZI

JULY , 2015

DEDICATION

This dissertation is dedicated to my parents; Dr. and Mrs. Arthur/Martha Mugisha, my brothers Mr. Dean Nkoba and Mr. Derrick Tindimwebwa. Each family member has been a true inspiration and given all the support and guidance that I needed.

May the good Lord continue blessing them.

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ACRONYMS

DAMA- Data Management Association

GDDS- General Data Dissemination System

IMF- International Monetary Fund

UBOS- Uganda Bureau Of Statistics

MDGs- Millennium Development Goal

AIDs- Acute Immune Deficiency Syndrome

USAID- United States Agency for International

ABSTRACT

The study was intended to investigate the relationship between data and health policy formulation in Uganda with references to Bugiri, Buyende, Iganga, Jinja. The objectives of the study were to analyze the level data collection in the formulation of health policies, to analyze how data for health policy formulation process is collected in Uganda and to establish the challenges faced in the collection of data for health policy formulation in Uganda.

To achieve the above objectives, the researcher collected primary data and secondary data. The researcher used cross sectional research design and frequent distribution tables were used to data presentation and analysis where a sample of 120 respondents from Busoga Region where purposive sampling and simple random technique were used.

The research findings showed that health policy formulation revealed that different disciplines and theories, helps the reader to understand the role of actors, as well as of political, economic and contextual factors in shaping policies and strategies that directly affect how a particular health system performs.

The researcher recommended that designate or develop a clearinghouse/resource center for Uganda data and data analyses. As part of its responsibilities, this unit would actively search out all sources of data and analyses and publicize their existence.

CHAPTER ONE
BACKGROUND

1.0 Introduction

This chapter presents the background of the study, statement of the problem, purpose of the study, objectives of the study, research questions, and scope of the study, significant of the study.

1.1 Back ground of the study

There is increasing recognition that the humanitarian aid system needs to be strengthened in order to improve its impact on vulnerable populations caught up by emergencies situations. The health policy processes and the development of health policy frameworks to guide humanitarian actors in providing health services. This is commissioned by the WHO's Emergency and Humanitarian Action (EHA) Department to determine the extent of knowledge about health policy formulation in emergencies situated areas and post-conflict countries (Smith, K. B, 2002).In emergencies, weak epidemiological, social and political analyses, combined with different mandates, perceptions and values of organizations often result in incoherent, fragmented health responses. It is proposed that improved health policy formulation will lead to more coordinated and effective health service provision, and decrease excess morbidity and mortality. Improved policy formulation may also facilitate the early phase of a country's transition to post-conflict. The transition between post-conflict and complex emergencies is a fluid one, and countries sometimes oscillate between the two phases when power structures remain weak. Once a country has moved into a stable post-conflict phase, policy-makers should broaden their perspective and focus on the creation of a sustainable health system (Ettelt et al., 2007).

Where appropriate the focus on agencies, autonomous and semi-autonomous bodies and other subsidiary organizations involved in the execution of its responsibilities. The unit of analysis is the policy processes within national ministries of health and the related agencies. Previous work has highlighted the substantial organizational differences between ministries of health and related agencies in a number of (European / high income) countries and the different roles which ministries of health and related agencies exercise in

relation to key health policy decisions, such as public coverage of health services (Ettelt et al., 2010).

The Population of Uganda is now 34.9 million according to the released National Population and Housing Census 2014 provisional results by the Uganda Bureau of Statistics (UBOS). With a population density of about 120 persons per km2, Uganda is one of the most densely populated countries in Sub-Saharan Africa. Eighty eight percent of the population lives in rural areas. Uganda has made progress in improving the health of its citizens: life expectancy increased from 45 years in 2003 to 52 years in 2008; polio and guinea worm have nearly been eradicated but concerns exist about the re-emergence of polio cases due to cross border migration; and prevalence of other vaccine preventable diseases has declined sharply. Between 1995 and 2005, U5MR declined from 156 in 1995 to 137 deaths per 1,000 live births; IMR decreased from 85 to 75 deaths per 1000 live births; and MMR reduced from 527 to 435 per 100,000 live births. Under-weight prevalence reduced from 23% to 16% over the same period. These health indicators are still poor.

Uganda launched a five-year master plan to control and eliminate all neglected tropical diseases endemic in the country in October 2013. The plan provides a road map for Uganda to be free of the neglected tropical diseases and related morbidity and disabilities by 2020. According to the Research Triangle Institute, newsletter, and Neglected tropical diseases because blindness, worm infestation, severe enlargements of limbs such as legs and feet, and impair childhood growth. These preventable diseases are still prevalent and common in many parts of Uganda, and they cause severe disability in the world's poorest countries, resulting in billions of dollars of lost productivity. Recently, jigger infestations were added to the list of the tropical diseases that the Ministry of Health is focusing on. Jiggers have been a painful embarrassment over the past decade, at alarming levels of infestations in Uganda.

The British Broadcasting Cooperation sent a team to Uganda and BBC's Robert Ilukoli in Jinja, 5th April, 2008, was reported to have said that, the Busoga region in western Uganda had an alarmingly high rate of jigger infestations. At the beginning of 2008, an outburst of

jigger infestations in Busoga region caused quite a stir in the media. A family of five interviewed by Robert Ilukoi in Jinja, caused wide spread shock by the condition they were found in. According to the Uganda Village Project, in October, 2010, the Ministry of Health, in partnership with several NGOs launched the National Jigger Campaign. The campaign involved a clinic in Kamuli, where over 300 people suffering from jiggers turned up to receive medical assistance in removing jiggers and having infections treated with antiseptics and antibiotics. The Humanist Uganda, reported that, at least 10 people infested with jiggers were admitted to Nsinze Health Centre IV in Namutumba District in July, 2014. The different reports over the years about the jigger infestation in Busoga region are overwhelming and alarming. This has contributed greatly to the underdevelopment in this region. The population is unproductive because of the recurring jigger infestations that leave the youth and elders helpless and weak.

1.2 Statement of the problem

The Ministry of Health has the mandate to set up policy formulation and policy dialogue with; health development partners, resource mobilization and budgeting, strategic planning, provision of nationally coordinated services such as epidemic control in order to reduce the level of epidemic diseases like jiggers in eastern Uganda. Therefore Health policy analysis in Uganda is limited and in-depth case studies examining the health policymaking process are lacking. A recent priority setting exercise from the region called for conducting case studies in selected countries to better understand the health policymaking process (El-Jardali et al., 2010). However the jigger infestation ailment is still recurring, the situation is still the same. The people in this region need assistance and even though different strategies and programs and even funding have been allocated to this cause, the infestation continue reoccurring and they have impacted on the population of this area negatively to the productivity of the population. Studying the role of evidence in policymaking through careful policy analysis allows a better understanding of the contribution of research in the formulation of policies, factors influencing success or failure, and why some issues get into the policymakers' agenda (Trostle et al., 1999 and Buse et al., 2007). This is due length health policy formulation in the country. Therefore the researcher seeks to investigate on the effect of health policy formulation and data.

1.3 Purpose of the study

This study's purpose was to investigate the impact of data on formulation of health policies that affect the population Health and development of Uganda.

1.4 Objectives of the study

The study was guided by the following objectives

- To analyze the level data collection in the formulation of health policies.
- To analyze how data for health policy formulation process is collected in Uganda
- To establish the challenges faced in the collection of data for health policy formulation in Uganda.

1.5 Research questions

In order to arrive at the above set objectives, the study was guided by the following questions

- What the level data collection in the formulation of health policies?
- How data for health policy formulation process is collected in Uganda?
- What are the challenges faced in the collection of data for health policy formulation in Uganda?

1.6 Scope of the study

Content scope

The study put into consideration nature of health policy formulation process, factors that determines the level of data collection for policy formulation and challenges faced in health policy formulation

Time scope

This study considered the current period that is 2015. This time period is chosen because it has the current data for policy formulation and the jigger affected areas.

Geographical scope

The study took into account the area that are affected by jiggers that is to say Bugiri, Buyende, Iganga, Jinja, Kaliro, Kamuli, Luuka, Mayuge, Namayingo and Namutumba.

The sub region has had chronic jigger infestation outbreaks over the past years and of all the districts in Busoga region, the districts that were reported to have jigger infestations.

1.7 Significance of the study

The study helped population health an important part of development in a country. This contributed to the health of the population and its wellbeing, but also to the general economic growth and development of the country.

The study provided good governance and proper functioning of the government and nongovernment bodies participating in the running of a country. Thus health is of great importance in the development and running of a country.

This study identified and analyzed the role of data in the formulation of government policies, as a way of better understanding its importance and also to monitor the evaluation of the policies.

This identified the flaws in formulation of these policies and helped formulate an evaluation of the efficiency of this process in the improvement or development of population health.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter reviews the existing literature on data on formulation of health policies. It presents those available studies in relation to the study objectives. It starts with the health policy formulation process, proceeds to that determines the level of data collection for policy formulation and lastly provides the challenges faced in health policy formulation.

2.1 The level data collection in the formulation of health policies

Data can be better defined as, "a reinterpretable representation of information in a formalized manner suitable for communication, interpretation or processing." Thus the data collected by the Health Management Information System, is interpreted and presented to the different Ministry departments involved in the formulation, implementation and evaluations of policies (Feltus, Christophe, 2008).Uganda public policy makers and administrators, business executives, and non-profit leaders require convenient access to accurate, timely data and analysis concerning the state, its communities, its citizens, and its economy to carry out their responsibilities properly (Heckathorn, Douglas D.; Maser, Steven M. ,1990).

Some leaders feel that information they need is not available or is difficult to find or use. As a result, they have problems determining if public initiatives are effective, comparing Uganda progress against other states, and clarifying strategic gaps that the state should address. This is because data cuts across all governing sectors of a country. One major way of improving the welfare of people residing in Uganda, is through the improvement of population health. This is because, as explained earlier, it is a key factor in development. Population health is acted upon through the implementation of policies formulated by the Ministry of Health (De Janvry, Alain, Dethier, Jean-Jacques, 2012).

Some policy makers say they are able to obtain the data they need and are reasonably satisfied with the current situation. Many others are very dissatisfied with the current data environment. Their dissatisfaction is caused by a long list of problems. Most of these issues result from two fundamental conditions throughout state and local government: lack

of sufficient resources allocated to data-related activities and limited implementation of information technology (Heckathorn, Douglas D.; Maser, Steven M. (1990). These problems were identified by individuals from outside and inside state government. When policy makers say that they cannot get the data they need, they often really mean that they cannot get data in a form that is useable for their purposes (Feltus, Christophe ,2008). In many instances, policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves. While there are many places where interpretations of some kinds of data for Uganda can be found, policy makers looking for timely non-partisan interpretation of a particular type of data are lucky if their search is successful (Greenberg, George D. et al, 1977). As a result, they may have problems determining if public initiatives are effective, comparing Uganda progress against other states, and clarifying strategic gaps that the state should address.

Workforce Data

For data relating to workforce issues, the primary sources of data are the Uganda Department of Workforce Development (DWD, the state agency responsible for producing employment, unemployment, wage, and other labor market information for Uganda as part of the national data program funded by the U.S. Bureau of Labor Statistics (BLS)) and STATS Uganda. Some analysts also go to the BLS website to access Ugandan data. For detailed workforce data relating to specific sectors not available from the sources mentioned previously, policy makers must turn to studies based on information collected by special surveys, such as the Uganda Health Industry Forum's Uganda Health Industry Workforce Study**,** or to special tabulations of the Uganda ES202 file (a DWD dataset containing employment and wage data from individual firms). Data gaps identified by policy makers are information about the skills and training of the workforce, more detailed data on the supply and demand for workers in specific industries and/or occupations, and more detailed workforce projections.

Economic Data

For other types of economic information, the primary sources are either STATS Uganda or the federal agencies that compile much of the data, such as the U.S. Census Bureau and

the U.S. Bureau of Economic Analysis. Again, those from outside the Central Uganda region often go to the research centers at IPFW and Ball State for some of their data needs. More information relating to the small business sector and entrepreneurial activity in the state was mentioned by policy makers as critical data needs.

Government Data

For data relating to state finances, the primary sources are the State Budget Agency and the Department of Revenue. For financial information relating to local governments, the primary source is the Department of Local Government Finance, and for school districts, it is the Department of Education (Center for Philanthropy, 2004). Obtaining other than summary data usually involves making a request for the information to the agencies. For other types of information relating to the government sector, policy makers rely on information from the individual state agencies and from non-governmental organizations, such as the Association of Uganda Counties, the Uganda Association of Cities and Towns, and data from the U. S. Census Bureau (Census of Governments). Criticism of both the quality and quantity of information available relating to the government sector was widespread among policy makers. The lack of performance and cost measures for all levels of government, information about the local impacts of government policies, and difficulties with obtaining data for local governments were mentioned most often(David Broomhall ,1994).

Education Data

The primary source of information relating to K–12 education in Uganda is the state's Department of Education through its IDE Anet web portal and off-line databases. For higher education data, those in higher education generally go to national sources, such as the National Center for Educational Statistics, the National Association of Independent Colleges and Universities, and the Association of American Universities (Ross DeVol and Rob Koepp, with Junghoon Ki, 2004). Others use the national sources but also get information from the state's Commission on Higher Education and the Uganda Association of Independent Colleges. Gaps in education data cited by policy makers are

information relating to adult and career education and more detailed enrollment and graduation data.

Health Data

The primary local sources for data relating to health and health care are the Department of Health, the Uganda Hospital and Health Association, and the Uganda Health Industry Forum (Greenberg, George D. et al, 1977). In most cases, it is necessary to make a request for the information, since these sources provide only minimal data on their websites. These in-state sources are supplemented by information provided by national sources, such as the National Center for Health Statistics and the Center for Disease Control (Lowi, Theodore J, 1985).

Data Relating to Social Well-Being

There is no single source of state-wide information relating to the different dimensions of social well-being. The annual *Kids Count* report and its related database, both products of the Uganda Youth Institute, provide data relating to many social measures, not all specific to children (Heckathorn, Douglas D.; Maser, Steven M, 1990). Policy makers interested in data relating to the Uganda metropolitan area can access a wide range of social data through the SAVI database (Smith, K. B, 2002). Many policy makers needing only summary information often find it more convenient to access Uganda data from national sources using the Internet. For more detailed data relating to a particular social issue, the typical approach is to go to the appropriate state agency – the Family and Social Services Administration for social service data, the Department of Environmental Management for data relating to the environment, etc. In most cases, this involves making a request for the information, since most agencies provide only minimal data on their websites (Kellow, Aynsley, 1988). Data relating to social well-being was another area in which policy makers had numerous complaints relating to both quality and availability (Lowi, Theodore J, 1985). Probably most critical is the need for more and better information of all types for areas outside of the metropolitan Uganda polis area (Spitzer, Robert J, 1987).

2.2 The Concept of Policy Formulation

Policy refers to the laws, regulations, courses of action and funding priorities related to a given issue. At the federal government level, health policy regulates commerce, industry

and transportation; provides for the safety of citizens at home and abroad; supports state and local governments; and contributes to the formation of social initiatives. The development and implementation of a health policy typically goes through a number of phases that are referred to as the policy cycle. Although the process is often complex and unpredictable and does not always proceed in a linear fashion, the policy cycle model provides a rough frame of reference for understanding the process. These are the sequential phases of the health policy life cycle.

The term may apply to government, private sector organizations and groups, as well as individuals. Presidential executive orders, corporate privacy policies, and parliamentary rules of order are all examples of policy. Policy differs from rules or law. While law can compel or prohibit behaviors (e.g. a law requiring the payment of taxes on income), policy merely guides actions toward those that are most likely to achieve a desired outcome. Policy or policy study may also refer to the process of making important organizational decisions, including the identification of different alternatives such as programs or spending priorities, and choosing among them on the basis of the impact they will have. Policies can be understood as political, management, financial, and administrative mechanisms arranged to reach explicit goals. In health corporate finance, a critical accounting policy is a policy for a firm/company or an industry which is considered to have a notably high subjective element, and that has a material impact on the financial statements.

Policy formulation involves developing strategies for dealing with policy issues which have been placed on an agenda**.** Policy formulation takes both the effectiveness and the viability or acceptability of proposed actions into account. Effectiveness refers to valid, workable strategies that address the situation, while acceptability refers to those strategies which are more likely to be put into action. Developing health policy begins with a set of guiding principles and by identifying issues, goals and objectives. In the analysis phase, the issues are carefully considered and various possible courses of action are proposed. The list of recommendations is then discussed by the policy makers and a decision is made based on the available information. An ideal policy is both feasible and acceptable. In most situations involving health policy, planners who may include health employees, as

well as outside groups or individuals, work on the initial stages. Other parties, such as town council members or a company's board of directors, typically examine the information gathered and make the final decision as to what will be implemented.

Policy formulation is the part of the process by which proposed actions are articulated, debated, and drafted into language for a law or policy. Written policies and laws go through many drafts before they are final. Wording that is not acceptable to policymakers key to passing laws or policies is revised. For example, a policy in Jamaica to support providers to serve minors (under the age of consent) went through numerous drafts over a period of two years before it was passed in 2003. The final version of the policy contained more references to promoting abstinence than did the first version. International conference declarations and programs of action also go through iterations during formulation. Leading up to the 1994 ICPD in Cairo, the draft Program of Action contained "bracketed" text that required negotiation and policy dialogue among stakeholders from around the world in order for the final document to be ratified.

Policy formulation includes setting goals and outcomes of the policy or policies (Isaacs and Irvin, 1991; Health Canada, 2003). The goals and objectives may be general or narrow but should articulate the relevant activities and indicators by which they will be achieved and measured. The goals of a policy could include, for example, the creation of greater employment opportunities, improved health status, or increased access to reproductive health services. Goals and outcomes can be accessed through a number of lenses, including gender and equity considerations.

The importance of evidence-informed health policies in improving health, reducing health inequities and contributing to economic development is increasingly recognized (Hanney et al., 2003). The Beijing, Montreux, and Bamako calls to action emphasized the importance of Knowledge Translation and urged national governments and international development agencies to continue to promote and finance Knowledge Translation towards the application of evidence-informed policymaking by developing trust between researchers, practitioners and policymakers, and drawing on multiple sources of knowledge (Global Ministerial Forum on Research for Health, 2008).

2.2.1 Data for health policy formulation process is collected in Uganda

The involvement of businesses and civil society - consumers, private entrepreneurs, employees and citizens and community groups, NGOs in designing health policy is critical if the Government of developing countries are to improve the transparency, quality and effectiveness of their policies as well as establishing the legitimacy of the health policy. Socio-economic and political conditions of a country determine or shape the network of a particular policy, so we explore recent research examining linkages between models of economic development and welfare regimes in developing countries where are known as weak institutional capacity, lack of accountability to the citizen to predict the policy formulation in developing countries. As a preliminary effort to remedy this shortcoming in the literature, we offer a political logic for the observed variation in the character of institutions of social policy established by nondemocratic regimes. Pross (1986) described the policy community as a network of individuals, groups, government departments, organizations, and agencies that dominate decision making in a specific policy field.

Accordance to Hai Do (2010), the dominant model of policy formulation in developing countries is the bureaucratic politics amongst the interrupted equilibrium, organizational process, and rational actor. Frans Van Waarden (1992) combined Rhodes's analysis with eight basic types of subsystem in Atkinson and Coleman (1992) to issue seven criteria on which the network can be varied: number and type of actors, function of networks, structure, institutionalization, and rules of conduct, power relations, and actor strategies. Howlett and Ramesh (1998, 2003) continued to construct the taxonomy of discourse communities which are two dichotomous dimensions in dominant idea set and numbers of idea set can be realistically applied for the analysis in a place of policy formulation. In additional, studying the interest networks, the taxonomy of interest networks which are again dichotomous dimensions of dominant actor and number of members, so these variables are shaping the structure and behavior of the policy networks (Howlet and Ramesh, 1998, 2003). The two variables and additional dominant idea set and numbers of idea set are used to discuss on the process of health policy formulation in developing countries.

In order to operate on the research question, that who does the policy design? And what are the motivation and participation of different actors with their entrances of new actors with new ideas who will actually play their roles in the policy design process? The research worked on the key variables such as dominant idea set and number of idea sets in the policy communities and variables of dominant actor and number of membersin shaping the structure and behavior of policy networks. 'Discourse' can also refer to dialogue, language, and conversation within the policy communities. The individual policy maker is substantially used as the unit analysis in this research. The research established the following hypotheses to address the research questions

Policy design

Most of policy sciences have known that the policy formulation uses the concept of policy design to emerge in response to implementation studies of policy systems which responsible for policy failure in 1970s-1980s. Most of policy design theorists given that the causal chain is the main cause of policies success or failure because the policy designs contribute to policy outcomes (Hai Do, 2012). Firstly, the policy design will need to specify the lists of policy instruments, institution-building (Weimer, 1992). Continuously, Fischer (2000) and Rixecker (1994) provided that the innovation and creativity are often raised from attention to the voices that contribute to the policy dialogue. Some other scholar focuses on policy discourse and dominant ideas. It consists of competing efforts to make meaning as much as to win votes. Indeed, the pursuit and exercise of power includes constructing images and stories, and deploying symbols (Fischer and Forester 1993; Rochefort and Cobb 1994; Schneider and Ingram 1997, 2005; Stone 2001; Yanow 1995).

Due to technical endeavor, leading them to characterize policies as "well" or "poorly" designed (e.g., Ingraham 1987; Linder and Peters 1985); this technical matter are popular in developing countries (Do, 2011). The scholars described a policy as well-designed if a careful analysis of means-end relationships. Thus, they tend to understand policy design as a political process preceding every policy choice (Bobrow and Dryzek 1987; Kingdon 1995; Schneider and Ingram 1997; Stone 2001). However, the options that address policy goals and instrument types require the injection of some new ideas and thinking into

policy deliberation (Howlett and Ramesh, 2003). Proposals for policy and program changes tend to arise from new actors in existing policy process, while changes relating to instrument types and components tend to develop among existing actors as their preferences change

In policy formulation, the relevant actors are usually restricted to members of policy subsystems, since a requirement of participation at this stage of the process is some minimal level of knowledge in the subject area, allowing an actor to comment, at least hypothetically, on the feasible of options put forward to resolve policy problems (Howlett and Ramesh, 2003). This is necessary for developing countries to define the policy regime as the dominant actor is belonged to state, but not from the civil society; the limitation of participation of the civil society is popular.

Policy tools

The policy tools or governing instruments that governments use to put the policies into the effect (Howlett and Ramesh, 2003). Over time, a subset of policy literature has focused explicitly on policy tools. Bardach (2005) offers eight-step framework of policy analysis, describing taxes, regulation, grants, services, budgets, information, rights, and other policy tools. For each tool, he suggests why and how it might be used, and what some of the possible pitfalls could be, aiming to stimulate creativity in crafting policy. Hood (1986) analyzes a range of government tools in significantly more detail with the ultimate aim of making sense of government complexity, generating ideas for policy design and enabling comparisons across governments. The wave of scholars use policy tools documents as trends away from direct provision of government services and toward measures that embed government officials in complex collaborative relationships with other levels of government, private-sector actors, and non-government organizations. These arrangements grant government parties much greater discretion than the close supervision and regulation of the past (Salamon, 2002). These indirect measures include contracting, grants, vouchers, tax expenditures, loan guarantees, government-sponsored enterprises and regulations, among others; many do not appear on government budgets in which he suggests helps to explain their popularity. The research on policy tools highlights the political consequences of particular tools, as well as their underlying assumptions about

problems, people, and behavior. Salamon characterizes the choice of tools as political as well as operation. Additionally, tools require distinctive sets of management skills and knowledge, thus the choice of tools ultimately influences the nature of health management. Before Lowi did classify, however it was not complete at yet that time. The tools are classified under organizational based instruments, authorized based instruments, information-based instruments (Howlett and Ramesh, 1998, 2003). In the developing countries, the selection of policy tools become very important step in the policy making process; however, the choice of the policy tools is often limited due to unavailable instruments in adequacy. The limited tools to select, leading to weak capacity of policy makers as well as institutional framework for policy making in developing countries. We will need to look at this in the discourse analysis.

In policy sub-system (Howlett and Ramesh, 2003), the actors and institutions exist in a mutually relationship. State actors are included: elected officials, appointed officials, business actors, labour, health, think-tank and research organizations, political parties, mass media, interest groups (ibid, 65-84). In examining roles of actors in developing countries in various cases and sectors, it is shown that there is a difference at roles and motivation and participation in the community discourse analysis while the state and business often keep their dominant roles in the policy process.

The participation of collective civil society actors for direct citizen participation in the policy formulation depends upon the institutional spaces where they are weak in developing countries. Many political leaders, policy-makers and researchers believe that such forms of direct citizen participation can help democratize and rationalize the state, as well as provide politically marginalized populations with a say in policy (Peter P. Houtzager, AdriánGurzaLavalle and Arnab Acharya, 2003). The institutional design of participatory policy-making spaces has a significant impact on who participates, and that this impact varies by type of civil society actor while there is no evidence that the "wealth" of collective actors influences participation.

In fact, there is a tendency that growing recognition of regulation which is not the exclusive domain of the state in developing countries with democracy regime. The

regulatory capacities of non-government actors are increasingly recognized and on occasions formally co-opted by the state. A variety of economic and civil society actors contribute to the information gathering, standard setting and behavior modification aspects of regulatory control (Bridget Hitter, 2012).

With the shift toward evidence-based policy reform in a part of developing countries in democratization, there is an opportunity to improve inclusiveness and participation in the policy cycle by engaging transparently with a wide range of state and non-state actors (Hai Do, 2010). There is an ethical dimension for example social risk analysis, to gathering information, interpreting information, and making policy. Mechanisms of transparency and accountability can preferentially include the poor to empower them with respect to competing interests and potential allies (WB, 2007) by bringing stakeholders together at different levels to participate in stakeholder analysis workshops and other forms of group based assessment, creates additional institutional spaces for discussion about policy change.

Discourse of policy to communities

Policy communities play critical roles in health policy processes, among which the most important ones are those related to integration tasks performed. The term policy community is part of an idiom used by policy researchers, political scientists, and health administration scholars to signify the extra-formal interactions taking place beyond or outside the formal processes of government that occur in the interstices between and among government agencies, interest groups, corporations, industry associations, elected officials, and other institutions and individuals (Hugh T. Miller and TansuDemir, 2005).

Wilks and Wright (1987) proposed a three-fold typology including "policy universe," "policy community," and "policy network". Policy universe is the large population of actors and potential actors who share a common interest in industrial policy, and may contribute to the policy process on a regular basis (ibid). Policy community, on the other hand, refers to a more disaggregated system involving those actors and potential actors who share an interest in a particular industry and who interact with one another to mutual

benefit. Policy network, in their thinking, becomes a linking mechanism between and among policy communities.
Policy.

In developing world as well, a policy community is a special type of interconnected social formation, the communication and influence may flow in non-hierarchical patterns associated with governmental fragmentation (Mara S. Sidney, 1998). Policy communities indicate a policy process in which organized interests and governmental actors play a major role in shaping the direction and outcome of health policies (Hai Do, 2009). Discourses 'can be taken as an example of the capture and exercise of power by some sorts of people, arguments and organizations against others through specific happenings, in particular arenas, over various periods of time' (Apthorpe, 1986). Discourse communities share common level of understanding of a problem, its definition, and its causes.

During the discourse, taking dominant idea set employing a view of culture as a communicative phenomenon involving discursive engagement, which is deeply influenced by social and economic inequalities, some authors argue that the struggle to break free of poverty is as much a cultural process as it is political and economic. They analyze important examples of discursive spaces - health meetings in Indian village democracies, where villagers make important decisions about budgetary allocations for village development and the selection of beneficiaries for anti-poverty programs. They examine village democracies from South India to demonstrate how they create a culture of civic/political engagement among poor people, and how definitions of poverty and beneficiary-selection criteria are understood and interrogated within them. Through this examination, they highlight the process by which village democracies facilitate the acquisition of crucial cultural capabilities such as discursive skills and civic agency by poor and disadvantaged groups. They illustrated how the poor and socially marginalized deploy these discursive skills in a resource-scarce and socially stratified environment in making material and non-material demands in their search for dignity (Rao Vijavendra, Sanyal, Paromit, 2009). Thus, the intersection of poverty, culture, and deliberative

democracy is a topic of broad relevance because it sheds light on cultural processes that can be influenced by health action in a manner that helps improve the voice and agency of the poor .

In World Bank's twin features: lending to developing economies to achieve tangible results and advocating specific development policies. The national discourse play the important roles, while the Bank discourse explicitly recognizes that developing countries need to improve their governance and build the capacity of the health sector to improve living standards, the Bank's performance in assisting governments in building state capacity and achieving better governance outcomes has been disappointing (De Janvry, Alain, Dethier, Jean-Jacques, 2012).

Policy network

The policy network studied in EU in Rhodes (1984) Wilks and Wright (1987), the networks varied according to their level of integration, which was a function of their stability of membership, restrictiveness of membership, degree of insulation from other network and the health, and the nature of resources they control, along five additional dimensions that "the interests of the members of the network, the membership, the extent of members' interdependence, the extent to which the network is isolated from the other networks, the variations in the distribution of resources between the members". The policy network as being essentially interest-based (Howlett and Ramesh, 2003), participants were assumed to

The networks can help CSOs use evidence to influence policy processes in Enrique Mendizabal (2006) who studied the form and function of the policy networks in developing countries given that networks are growing in number in developing countries and between developing and developed countries. Both membership structure, socio-cultural norms are important such as the policy network focuses on some important functions so-called Filter, Amplify, Convene, Invest/provide, Build communities, Facilitate in which policy networks can carry out these functions within two broader roles of agency and support.

In the context of low level of capacity, the network can support the local government, from the research of Thunradee Taveekan (2010) on the formation and implementation of policy networks in village communities by assessing their performance but also its effects on local governments' performance and democratic governance with focuses on the relations between the sectors in policy process, in particular local governments and civil society groups in Thailand starting from the adopt on the good governance approach in 1997. The adopting of policy networks in Thailand is in the early stage, however, policy networks has been seen as a new intervention of the inclusive governance between state agencies and other sectors to greater participation in policy process at the local level. It concluded that the multi stakeholders including local government, citizen, civil society groups and central government representatives are all reacted in the positive way to optimize their performance together. On one hand, the local governments have changed their attitude and the ways of working from top-down approach to bottom up approach.

They also encourage social and business sectors to involve in policy making process as a partner. On the other hand, the civic and civil society groups have engaged themselves into the policy process by participating in policy networks. The policy networks resulted in the transformation of local governance by promoting civic and health participation, enhancing local accountability, creating direct political opportunity. Scaling up the level of trust and level of participation in various forms are the major factors of effective policy network performance without neglecting the greater communication. In addition, the relationships between local governments and civil society groups have been changed significantly. It is argued that their relationships have been reshaped from the separation and command to be the integration and dialogue through the concepts of good governance and network governance since 1997.

Accordance to Mai Thi Truong (2011), the poverty reduction has in one of the important social security policies in the socio-economic strategy of the State and has received much attention of the whole society. This has helped keep a balance between economic growth and equity and social progress, contribute to maintain social stability, sustainable

development and fulfill Viet Nam's international commitments. In many years, Viet Nam's efforts in poverty reduction have been paid off and Viet Nam has been a bright example in implementing the Millennium Development Goals.

Viet Nam's achievements have been recognized by the world health and people. In this case of Vietnam, the effectiveness of policy network performance in poverty reduction can be assessed by policy networks from donors to national actors and local actors. In the analysis of roles of 11 government agencies and networks of businesses and NGOs and mass organizations (social political organizations in Vietnam including Women Union, Youth Union, Farmer Associations etc). The Government formulated social policies with the implementation of state agencies with the participation of different actors to assist the poor and poor communities. We see that the policy networks of the dominant actors in government to pursuit their responsibilities to formulate the policy of poverty reduction led to the success of poverty reduction widely. The mass organization participated actively into the causes of poverty reduction with larger members of these agencies to the grass roots level. The international donors have been highly appreciated by their commitment and participation into the policy formulation.

2.2.2 Approaches to health policy formulation in developing world

The economic development of a country depends on the quality of its policy framework, the decisions taken, especially the processes involved in formulating each decision. It is clear also that developing countries throughout the world vary considerably in their ability, and perhaps their willingness to formulate and implement policies that will generate improved development performance (Joan Corkery, Anthony Land, and Jean Bossuyt, 1995). In health policy world, the policy formulation is part of the pre-decision phase of policy making.

This task includes the crafting identification of a set of health policy alternatives to address the socio-economic problems, and selection process by narrowing that set of solution in preparation for the final policy solutions for the next stage. In Cochran and Malone (1996), the policy formulation is to deal with the problem, goals and priorities, solution options for the achievement of policy objectives, cost benefit analysis, negative

and positive externalities are associated with each alternative. These stages embedded into the policy cycle which is now popular in developing world. However, the specification of policy alternatives does not follow neatly from the agenda setting process not lead neatly into implementation in Mara S. Sidney (2002) which is reflected the policy formulation in developing countries. Thus, the policy formulation is a function rather than a stage where dominant actors and set ideas shaping significantly during their course of actions.

Apparently, the function is more relevant for the developing countries where there are weak institutions, regulatory capacity, accountability and participation and responsibility of subsystem of government, so the formulation is the continuous process. The attention of policy formulation is also embedded in work on subsystem, advocacy coalition, networks, and policy communities (Weible and Sabatier,2008). The policy formulation is taken up in the agenda setting works in some researchers in 1995 to 1998 (Kingdon and Birkland,2005); however, the policy formulation is the work of the policy communities and policy networks (Howlett and Ramesh, 2002); it is apparent that identifying the policy actors, understanding their beliefs and motivations, their judgments of feasibility, and their perceptions of the political context which is relevant for developing world.

Thus, the policy formulation is the function of the policy making. It is really the practice oriented policy making in developing world. Also, the policy formulation within the policy communities and policy networks is reflected the actual policy in developing countries because the policy making in development work in environment with weak institutions and capacity within the communities and networks.

2.3 Challenges faced in data collection for health policy formulation Process in Uganda

Understanding the Policy-Making Process

Before rural communities can make attempts to impact public policy, it is important that they have an understanding of the policy-making process itself. The first working paper of this series, "A Brief Guide to Understanding Policy Development" (Rural Communities Impacting Policy, 2002) discusses the policymaking process, including key players, timeframe for policy development and steps for influencing policy. Understanding the

policy-making process can help individuals and community-based organizations decide whether they will become involved in trying to develop or change a policy and, if so, how to best go about it. Unfortunately, the policy-making process tends to be very complex making it difficult for almost anyone to understand it completely. However, understanding the process can help empower individuals and community-based organizations to impact policy.

Lack of Resources

In order for rural communities to play an active role in the policy-making process, it is necessary for their members to have access to resources. These resources include adequate funding, government training programs, education, leaders, and volunteers to support rural causes and initiatives. Many rural communities tend to lack one or more of these resources, a situation which interferes with their ability to effectively impact the policy-making process. Having inadequate resources negatively impacts a rural community's ability to effectively influence and develop policy compared to other players in the policymaking process. For example, corporations and professional organizations often have access to large amounts of financial and human resources. This creates an inequity whereby community organizations that may be equally or even more affected by policy change do not have the same opportunity to participate in and influence the process.

Reliance on Volunteers

Lack of access to financial resources necessary to address problems and concerns of rural community's leads to organizations relying on volunteers to carry out community-based activities. Low populations in rural areas can result in the availability of only a small number of volunteers to carry out all the necessary activities demanded by their community organizations. This situation can lead to a reluctance to become involved in the complex policy-making process. Even more difficult is finding individuals within rural communities with the skills, abilities and desire to initiate and champion rural policy development. Further, there tends to be a lack of programs to train, support and motivate new leaders and volunteers. As a result of a lack of these resources, some community leaders and volunteers face burnout that affects their productivity and progress in

furthering the work to help their community. In addition, the loss of youth from rural communities results in a depletion of potential future community leaders and volunteers. Another factor which can be considered contributing to the absence of a volunteer pool may be the political and social visibility that can result from becoming active in the policy-making process. Such visibility may be uncomfortable for some and emphasize the vulnerability of certain community members, for example, those of low socioeconomic status.

Lack of Access to Information

Rural citizens have indicated that they feel there is a lack of access to information about government programs and services. Rural Canadians have also reported that the information that is available on policy, government programs and services is difficult to obtain and interpret. There is a desire to learn about and access information about government programs and services that is understandable, concise and timely (Rural Dialogue, 2000). Recently, the Federal government has moved towards increasing access to information concerning programs and policies. Another information challenge is the fact that little research has been conducted concerning rural communities and the policy-making process. Further, this research often is difficult to obtain. Rural Canadians have also indicated that they need access to information specific to the status of their communities. Once again, this information, if available, tends to be difficult to access and may be expensive. One of the goals of the Rural Communities Impacting Policy (RCIP) project is to provide rural Nova Scotians with greater access to data specific to rural communities and how to use this data to better understand their communities and impact the policy-making process. Another paper in this series entitled, "Understanding the Link Between Research and Policy" (Rural Communities Impacting Policy, 2002), provides an overview of different types of research and how rural communities can use research to impact policy.

Absence of rural representation in the Decision-Making Process

Living in a democratic society, we elect representatives to speak on our behalf at the government level. By virtue of their larger population, urban areas tend to have greater

representation in the Federal parliament and Provincial legislatures than rural areas. The greater number of urban representatives is one factor that can lead these elected bodies to have a more urban focus and reduce the influence rural community members have in the decision-making process. Specific communities and groups of community members must also be considered in the rural policy-making process. Unfortunately, there are some groups who tend not to be well represented in the policy forum, for example, people with lower socio-economic status or First Nations communities.

The relationship between rural communities and government is strained by the community perception that governments do not understand rural issues and impose policies and programs that negatively affect rural Canadians. Even worse, there is sometimes not even agreement among key policy makers that circumstances in rural communities are problematic and deserving of government action (Doern & Phidd, 1988). Government is also seen as sometimes downloading responsibilities on rural communities without providing the necessary resources. (financial support, educational programs) for communities to assume these responsibilities. Further, rural community members get frustrated and discouraged by rejections of policy proposals by government and ever-changing program criteria. From the perspective of rural communities, the attitudes and action of governments have created barriers to working together to affect policy to improve the health and sustainability of rural communities. Rural community members often perceive government priorities and programs as detrimental to their community's health and sustainability. These perceptions create a barrier to community involvement in the policy-making process.

Time and Policy Timeline Restrictions

Often the policy timeline can create difficulties for communities looking to impact policy around a particular issue. Although government may be considering a policy change for a long period of time, the public consultation process may be relatively short and not allow community-based organizations the time to research and properly prepare to effectively participate. On the other hand, the policy-making process can take a very long time,

draining the resources of community-based organizations and frustrating those who want change.

Perceived Resistance of Communities as a Partner in Policy Development

Government policy makers who want to affect rural policy can sometimes be faced with community resistance to change. This may stem from the cultural identity of some rural communities and their reluctance to negotiate any of their beliefs and tradition even if the proposed change or policy could lead to improvements (Doern & Phidd, 1988). Another factor that may be reducing community involvement with change is the attitude that it is solely a government's responsibility to develop policy that benefits rural communities. Resistance to change can undermine government's ability to involve the rural community in the policy-making process.

Jurisdictional Issues

There are many layers of government, each with its own jurisdiction and responsibilities. However, it is difficult to develop policy in one jurisdiction without affecting another. Thus, there is a need to build bridges and collaborations between federal, provincial, municipal and First Nations governments concerning policy affecting rural communities. There is also a need for cooperation across departments within the same level of government. Historically, the structure of both the Federal and Provincial Governments resulted in a sector-based approach to policy development. For example, Federal Government departments tend to be organized around sectors such as forestry, environment, agriculture, fisheries, and mining. Each department has its own needs and responsibilities, providing a barrier to gaining an overall perspective on rural development. Recently, however, the Federal Government has begun to recognize the importance of rural Canada and has taken steps toward a more rural perspective. For example, Cabinet departments are required to examine new policy through a "Rural Lens" that forces them to consider the impact of the policy on rural Canada. In addition, the Rural Secretariat was created in 1996 as a focal point for the Government of Canada to work in partnership with Canadians in rural and remote areas to build strong, dynamic communities. From a rural standpoint, the need for intersect oral collaboration is

important if rural communities are to play an active role in the policy-making process. The creation of county "teams" in Nova Scotia i.e., Team Cumberland, is an example of the way rural communities can work together.

Attitudes of government toward rural communities

Among some government policy makers, an "urban bias" may exist whereby the government pays more attention to larger, industrial centers. This "urban bias" may arise from the fact that some government members have only lived in urban communities, the lack of available information concerning rural communities, urban areas having a greater number of elected government officials, and government dependence on the political support of urban areas to stay in power. Whatever the reasons, the existence of an "urban bias" can lead to a preoccupation with urban centers at the expense of rural communities. Policies and programs created with urban centers in mind sometimes are made to fit rural communities. Unfortunately, these types of policies and programs have a tendency to ignore rural issues and cannot be considered equal in both urban and rural areas.

Structural Barriers within Government

Both government and rural communities can be frustrated by the lack of opportunity to communicate with one another. This limitation may be partially the result of an absence of "listening mechanisms" within the government structure itself. Government departments are primarily concerned with their own area and there are relatively few mechanism by which information can be conveyed across departments. This "silo effect" can be frustrating for community organizations whose concerns may span across the jurisdictions of more than one department. Further, other than for occasional public consultation processes, there is little opportunity for individuals or community-based organizations to speak to government representatives around their policy concerns and issues.

2.4 Conclusions

Understanding the interactions of policy actors is hence a key facet of understanding the policy process. The policy formulation in developing countries has a difference with developed countries by weak institutional capacity and lack of accountability of state actors. The policy design is often done by state agencies while there is varied in

participation of businesses and civil society - consumers, private entrepreneurs, employees and citizens and community groups, NGOs at both form and functions. Thus, the policy communities indicated a policy process in which organized interests and governmental actors play a major role in shaping the direction and outcome of health policies and the discourse communities of the dominant idea set always decided the structure of the policy communities. Discourse communities share common level of understanding of a problem, its definition, and its causes. During the discourse, taking dominant idea set employing a view of culture as a communicative phenomenon involving discursive engagement, which is deeply influenced by social and economic inequalities. The participants of the networks with an aim to further their own needs play critical roles in shaping the structure of the networks. Thus, the structure of the subsystem decided the roles of the dominant actors of the policy network, form and functions and the motivation and participation of different actors.

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter presents the methodological techniques that were used in collection and analysis of data during the research study. It consisted of the research design, population study, study area, sampling design, sample size, source of data, tools of data collection, methods of data collection and data processing, analysis and presentation.

3.1 Research design

This study was conducted using the correlation research design. This design simply entailed the collection of data from two quantifiable variables from one population, which

is then compared to see how they differ. In the case of this study, data (A) from the hospitals and health centers (which is sent to the Ministry Of Health for the formulation of policies) , and data (B) from the actual people living in this jigger infested area, are the two quantifiable variables, whose data will be collected and later compared. Correlation research design will avail us with a means of determining to what degree a relationship exists between the two variables (data A and data B). Data plays a very important role in the formulation of effective policies. To carry out this study, the data availed to the Ministry Of Health headquarters for the formulation of policies to curb epidemics and health related problems, will be compared to the data from the actual homesteads and the population in this area.

3.2 Population and sample size

3.2.1 Population study

The target population was 52,000 respondents from households affected with jiggers. These figures are lower than that of the day population estimated to fluctuate.

3.2.2 Sample size

Out of 52,000 residents a sample size of 384 respondents was considered according to (Krejcie Morgan 1970). But because of time and fund constraints the study was consider 120 respondents from area affected by jiggers Busoga region.

3.3 Source of data

Two sources of data collection was used, which included primary data and secondary data. This consisted of first hand data from the field that will be obtained directly from the particular study. Primary data was obtained from local people in Busoga region through the responses provided in face to face interviews and filled questionnaires among others. Secondary data was obtained from already existing literatures such as text books, journals, annual reports, news papers, magazines and internet search among others. Only relevant information was considered for the research study.

3.4 Method of data collection

Questionnaires

A carefully structured questionnaire was administered to the respondents in which they were be subjected to a set of questions so as to solicit answers from them. The questionnaires contained objectives questions that required short answers. These questions were formulated from the study objectives**.**

Observation

This instrument of data collection was involved the use of all senses to perceive and understand the experiences of interest to the study. These questions help remind the researcher about the key factors to look out for during the research process while in the population habitat. The researcher moved from the local council leaders to the hospitals and health centers, and finally to the homesteads in the different quota groups. Observations that was useful to the study can be made from all these areas where the research was carried out, but the most important places to look out for important observations or information are, the hospitals, health centers, and homesteads.

3.5 Data processing and Analysis

Completed questionnaires were collected from the respondents. The information was got from the filled questionnaires which sorted and edited to ensure completeness and accuracy. Data was presented using frequency tables. Tables helped to summarize the data using descriptive statistics such as percentages. Later on data was analyzed using Microsoft excel. This helped to summarize the data into tables and also showed the relationship between the variables.

3.6 Limitations/ Problems Encountered

The limited timeframe within which the researcher operates presents a peculiar to the study. Study time and work schedule will be tight therefore greatly limited more extensive research.

Costs of the research were high. Due to the limitation highlighted above. It would therefore, be appropriate to make a similar study in future in order to lessen the impact of the timing of the field study and the anxiety in the minds of the employees.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter contains the presentation, interpretation and analysis of findings based on research objectives. The objectives were to analyze the nature of health policy formulation process in Uganda, to examine the sources of data for policy formulation in Uganda and to establish the challenges faced in health policy formulation in Uganda. Response rate

4.1 Demographic characteristics of respondents

The demographics considered under this area are gender of respondents, current department, age brackets, level of education and the duration respondents had spent in the area of study. The summary of this is shown in the different tables that follow.

4.1.1 State your current area of operation

Under this area, the researcher was interested in establishing the distribution of respondents within the area of research operation. The summary of these findings is illustrated in the table 1 shown below.

Table 1 : Area of operation

	Frequency	**Percent**
Internal Audit	2	1.7
Finance and human resource	30	25
Clinic	16	13.3
Laboratory	14	11.7
Data	28	23.3
Operation	30	25.0
Total	**120**	**100.0**

Source: Primary data

From the above table 2 on the previous page, it is indicated that the number of respondents whose department was internal audit were 2 (1.7%), Finance and Human resource 30 (25%), Clinic 16 (13.3%), Laboratory 14 (11.7%), Data 28 (23.3%) whereas those whose department was operations 30 (25.0%). This implies that majority of the respondents were from research and development contributing 25% of the total response rate. In regards to the area of study, the findings reveal that they employ more staff within Research and development departments as compared to other departments. This is justified because the organization is a clinical related company that requires a lot of innovations and inventions which can only be achieved through research and development.

4.1.2 Title in the area of operation

The respondents were also asked to give their titles in respect to their positions they hold in the area of operation and their responses are shown in table 2 below.

Table 2: Job Title

	Frequency	**Percent**

Chairman	20	16.7
Treasury	45	37.5
Voice chairman	51	42.5
Total	**120**	**100.0**

Source: Primary Data

Table 2 above indicates that the number of respondents who were chairmen was 20 (16.7%), treasurers were 45 (37.5%) while voice chairmen were 51 (42.5%). The results imply that the study covered all sections of the institutions management. The results indicated that majority of respondents were senior officers with 42.5%. This means that within the areas affected by jiggers, majority of the respondents there are voice chainmen.

4.1.3 Gender of respondents

The study was interested in understanding the gender distribution of the respondents. The findings to this effect are summarized in the table 3 below.

Table 3: Gender of respondents

	Frequency	**Percent**
Male	76	63.3
Female	44	36.7
Total	**120**	**100.0**

Source: Primary Data

From the above table 3 above, it is worth noting that the number of respondents who were males was 76 (63.3%) while females were 44 (36.7%). This implies that the study considered views of both sexes. The results also indicated that majority of the respondents were males with 63.3% contribution to the general response rate. This means that the number of males within the medical profession is more than females within the same profession. In relation to Busoga region, the results suggested that more men are employed as compared to females. The results are also in line with United Nations (2008) that

indicated that the proportion of men to women education in Uganda is given by the ratio of 3:1. Also, men are more flexible than females at work.

4.1.4 Marital status

The study wanted to establish the marital status of respondents and the results to this effect is indicated in the table 4 below on the next page.

Table 4 : Marital status

	Frequency	**Percent**
Single	47	39.2
Married	66	55.0
Widow	5	4.2
Divorced	2	1.7
Total	**120**	**100.0**

Source: Primary Data

From the above table, it is indicated that the number of respondents who were single were 47 (39.2%), married were 66 (55.0%), Widow 5 (4.2%) and those who had divorced were 2 (1.7%). This means that the study attained information from all forms of marital status that a person falls to check the consistencies in their responses. The results also indicated that the proportion of married employees were highest with 55%. This implies that within Busoga Region, married people are more considered as compared to other statuses.

4.1.5 Age of respondents

The study was interested in understanding the age distribution of respondents and the results to this effect is indicated in the table 5 that follows.

Table 1: Age bracket

	Frequency	**Percent**
18-24 years	11	9.2
25-31 years	56	46.7

32-38 years	28	23.3
39-45 years	17	14.2
46-52 years	4	3.3
Above 52	4	3.3
Total	**120**	**100.0**

Source: Primary Data

It was indicated in the table 5 on the previous page, above that the number of respondents whose age was between 18-24 years were 11 (9.2%), 25-31 years 56 (46.7%), 32-38 years 28 (23.3%), 39-45 years 17 (14.2%), 46-52 years 4 (3.3%) whereas those whose age was 52 and above were 4 (3.3%). The results mean that the study collected information across all age brackets. The results also further the biggest majority of respondents were less than 45 years of age with 96.7%. The results are in line with the population distribution of Uganda which indicates that the biggest population of Uganda's population is dominated by youths, (UBOS, 2009).

4.1.6 Academic qualification

The study wanted to establish the academic qualification of respondents and the results to this effect is indicated in the table 6 below.

Table 6: Level of Education

	Frequency	**Percent**
Certificate	14	11.7
Ordinary Diploma	9	7.5
Bachelors degree	45	37.5
Post graduate diploma	18	15.0
Masters Degree	31	25.8
PhD	3	2.5
Total	**120**	**100.0**

Source: Primary Data

From the above table 6, it is indicated that the number of respondents whose highest level of education was Certificate were 14 (11.7%), Ordinary Diploma were 9 (7.5%), bachelors degree 45 (37.5%), post graduate diploma 18 (15.0%), masters degree 31 (25.8%) and those who had PhD 3 (2.5%). The results mean that the study attracted views from members who had different education backgrounds. The results implies that majority of the respondents were degree holders with 37.5%. The results are consistent with Khisa, (2013), who indicated that in Uganda, over 400,000 youths graduate every year and they stand the highest majority on the labor market.

4.1.7 Years of service in the area

This study was also interested in establishing the duration spent by respondents while offering a service to the institution. The results to this effect are summarized in table 7 below.

Table 7: Years in service

	Frequency	**Percent**
Less than one	14	11.7
1-4 years	59	49.2
5-9 years	36	30.0
Above 10	11	9.2
Total	**120**	**100.0**

Source: Primary Data

The table 7 above indicates that respondents who had been in the institution for a period Less than one year were 14 (11.7%), 1-4 years were 59 (49.2%), 5-9 years 36 (30.0%) while those who had been with the institution for a period above 10 years were 11 (9.2%). This implies that majority of respondents had spent in the institution a period less than 5

years were 60%. The results further imply that that majority of the staff within Busoga region leaves the company before they can spend five years in service.

4.2 Data collection in the formulation of health policies

Table 9: Data collection in the formulation of health policies

Particular	SD	D	NS	A	SA	$\overline{X}$	Std.Dev
Some policy makers say they are able to obtain the data they need and are reasonably satisfied with the current situation	9 (7.5%	29 (24.2%	8 (6.7%)	50 (41.7%	24 (20%	3.43	0.261
One major way of improving the welfare of people residing in Uganda, is through the improvement of population health	5 (4.2%)	38 (31.7%	10 (8.3%	35 (29.2%	32 (21.7%	2.43	0.294
Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves.	4 (3.3%	23 (19.2%	21 (17.5%)	46 (38.3%)	26 (21.7%)	4.41	0.206
Administrators, business executives, and non-profit leaders require convenient access to accurate, timely data and analysis concerning the state	6 (5.0%)	38 (31.7%	25 (20.8%)	27 (22.5%	24 (20%	3.21	0.229
The primary sources of data are the Uganda Department of Workforce Development	2 (1.7%)	38 (31.7)	8 (6.7%)	42 (35%	28 (23.3%	4.00	0.229
Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves	24 (20%	35 (29.2%	2 (1.7)	34 (28.3%)	25 (20.8%	4.01	0.492
Data and analysis should serve to inform discussion about policy	16 (13.3	23 (19.2%	4 (3.3%	48 (40%)	29 (24.2	3.73	0.388

alternatives, to monitor progress toward strategic goals	%				%		
Data help in managing businesses, social services and public activities	9 (7.5%)	26 (21.7%)	6 (5.0%)	37 (30.8%)	42 (35%)	3.6 4	0.352

Source: Primary Data

Respondents were asked a number of questions in line with the sources of data for policy formulation, they responded accordingly. On whether Some policy makers say they are able to obtain the data they need and are reasonably satisfied with the current situation , the results obtained consisted a 50(41.7%) agreeing, 29(24.2%) strongly disagreed, 24(20%) strongly agreed, 9(7.5%) strongly disagreed and 8(6.7%) were not sure with a (Mean=3.43, SD=.261). This means that most respondents were not sure of the scenario. This is in consultation with Heckathorn, Douglas D.; Maser, Steven M. (1990) who said that some policy makers are able to obtain the data they need and are reasonably satisfied with the current situation with the majority respondents agreeing though others say that there is lack of sufficient resources allocated to data-related activities and limited implementation of information technology.

On whether One major way of improving the welfare of people residing in Uganda the improvement of population health, the results show that 38(31.7%) strongly disagreed, 35(29.2%) agreed, 32(21.7%) strongly agreed, 10(8.3% were not and 5(4.2%) strongly disagreed with (Mean=2.43, SD=.294) were acquired. This is consultation with De Janvry, Alain, Dethier, Jean-Jacques, (2012) who said that the major way of improving the welfare of people residing in Uganda, is through the improvement of population health. But based on the researcher view is that the majority respondents disagreed with issue.

The researcher also wanted to find out whether Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves and the results of 46(38.3%) agreed, 26(21.7%) strongly agreed, 23(19.2%) disagreed 21(17.5%) were not sure and 4(3.3%) strongly disagreed and (Mean=3.56, SD=.129). This is in consultation with Feltus, Christophe (2008) who said that policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves.

However on the other hand policy makers say that they cannot get the data they need, they often really mean that they cannot get data in a form that is useable for their purposes.

The findings on whether Administrators, business executives, and non-profit leaders require convenient access to accurate, timely data and analysis concerning the state, revealed that 38(31.7%) of respondents disagreed, 27(22.5%) agreed, 25(20.8%) were not sure, 24(20%) strongly agreed and 6(5.0%) disagreed and the (Mean=3.21, SD=.229) were achieved. This is in consultation with Heckathorn, Douglas D.; Maser, Steven M. (1990) who said that Uganda public policy makers and administrators, business executives, and non-profit leaders require convenient access to accurate, timely data and analysis concerning the state, its communities, its citizens, and its economy to carry out their responsibilities properly. However the majority respondents disagreed with the issue which implies that administrators, business executives, and non-profit leaders require convenient access to accurate, timely data and analysis concerning the state.

Result on whether the primary sources of data are the Uganda department of workforce development indicate that most respondents agreed with (Mean=4.00, SD=.229) were obtained. This implies that the primary sources of data are the Uganda department of workforce development where by 42 (35%) agreed, 38(31.7%) disagreed, 28(23.3%) strongly agreed and 2(1.7%) strongly disagreed. This is in line with Junghoon Ki (2004) who said that the primary sources of data are the Uganda Department of Workforce Development the state agency responsible for producing employment, unemployment, wage, and other labor market information for Uganda as part of the national data program funded by the U.S. Bureau of Labor Statistics and Statistics Uganda as evidenced by the majority number of respondents.

The findings on whether Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves, (Mean=4.01, SD=.492) were obtained. This means that majority of respondents agreed which implies that Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves. This was revealed by 35(29%) who disagreed, 34(28.8%) agreed, 25(20.8%) strongly agreed, 24(20%) strongly disagreed and 2(1.7%) were not sure. This is in consultation

with Greenberg, George D. et al, (1977) who argued that policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves.

Respondents were also asked whether Data and analysis should serve to inform discussion about policy alternatives, to monitor progress toward strategic goals and results of 40(48%) agreed, 29(24.2%) strongly agreed, 23(19.2%) disagreed, 16(13.3%) strongly disagreed and 4(3.3%) were not sure and (Mean=3.73, SD=.388) were obtained. This means that majority of respondents agreed. This is in consultation with Heckathorn, Douglas D.; Maser, Steven M., (1990) who said that timely data and analysis concerning the state, its communities, its citizens, and its economy to carry out their responsibilities properly. This implies that Data and analysis should serve to inform discussion about policy alternatives, to monitor progress toward strategic goals.

The findings on whether the Data help in managing businesses, social services, and public activities revealed that (Mean=3.64, SD=.352) was acquired with 42(35%) strongly agreed, 37(30.8%) agreed, 26(21.7%) disagreed, 9(7.5%) strongly disagreed and 6(5.0%) were not sure of the scenario. This means that majority of respondents agreed.

4.3 Data for health policy formulation process is collected in Uganda

Table 8: Data for health policy formulation process is collected in Uganda

Particular	**SD**	**D**	**NS**	**A**	**SA**	$\overline{\mathbf{X}}$	**Std.Dev**
Policy formulation is the part of the process by which proposed actions are articulated, debated	7 (5.8%)	9 (7.5%)	2 (1.7%)	60 (50%)	42 (35.0)	4.05	0.369
Policy formulation involves developing strategies for dealing with policy issues which have been placed on an agenda	0 (0%)	6 (5%)	0 (0%)	58 (48.%)	56 (46.7 %	4.83	1.135
Policies can be understood as political, management,	0 (0%)	8 (6.7%)	2 (1.7%	61 (50.8%	49 (40.8	4.66	0.948

financial, and administrative mechanisms arranged to reach explicit goals					%)		
The information is well established for health policy formation	0 (0%)	6 (5.0%)	2 (1.7%)	51 (42.5%)	60 (50.0 %)	4.02	0.21
Socio-economic and political conditions of a country determine or shape the network of a particular policy	6 (5.0%)	20 (16.7%)	4 (3.3%)	60 (50%)	30 (25%)	4.57	0. 905
Policy tools analyzes a range of government tools in significantly more detail with the ultimate aim of making sense of government complexity	2 (1.7%)	27 (22.5%)	2 (1.7%)	67 (55.8%)	22 (18.3)	4.05	1.02

Source: Primary Data

From the above table 8, it was indicated that respondents were asked whether Policy formulation is the part of the process by which proposed actions are articulated, debated results of (Mean=4.05, SD=.369). The implication of this is that policy formulation is the part of the process by which proposed actions are articulated, debated with 60(50%) agreed, 42(35% strongly agreed 9(7.5%) disagreed 7(5.8%) strongly disagreed and 2(1.7%) were not sure. This is in line with Isaacs and Irvin, (1991) who said that Policy formulation is the part of the process by which proposed actions are articulated, debated and drafted into language for a law or policy. This means that majority of respondents agreed.

On whether the Policy formulation involves developing strategies for dealing with policy issues which have been placed on an agenda, results of (Mean=4.83, SD=1.135) was acquired where 58(48%) agreed, 56(46.7%) strongly agreed and 6(5%) disagreed. This means that more than average respondents agreed. This is in consultation with Theodore J, (1985), policy formulation involves developing strategies for dealing with policy issues which have been placed on an

agenda**.** Policy formulation takes both the effectiveness and the viability or acceptability of proposed actions into account. This implies that policy formulation involves developing strategies for dealing with policy issues which have been placed on an agenda.

The findings of whether Policies can be understood as political, management, financial, and administrative mechanisms arranged to reach explicit goals, results obtained were a (Mean=4.66, SD=.948). This means that majority of respondents agreed. This implies Policies can be understood as political, management, financial, and administrative mechanisms arranged to reach explicit goals with 61(50.8%) agreed, 49(40.8%) strongly agreed, 8(6.7%) disagreed and 2(1.7%) were not sure.

The study also wanted to find out whether the information is well established for health policy formation with 60(50%) strongly agreed, 51(42.5%) agreed, 6(5.0%), disagreed and 2(1.7%) were not sure and results of (Mean=3.79, SD=.910) to this effect were obtained. This means that majority of respondents agreed that the information is well established for health policy formation.

Respondents were also asked whether Socio-economic and political conditions of a country determine or shape the network of a particular policy giving results of (Mean=4.57, SD=.905). The study discovered that 60(50%) agreed, 30 (25%) strongly agreed, 20(16.7%) disagreed and 4(3.3%) of the respondents were not sure of the fact. This means that majority of respondents agreed. This is in line with Hai Do (2010), who said that socio-economic and political conditions of a country determine or shape the network of a particular policy, so we explore recent research examining linkages between models of economic development and welfare regimes in developing countries where are known as weak institutional capacity. This implies that socio-economic and political conditions of a country determine or shape the network of a particular policy.

Responses on whether policy tools analyzes a range of government tools in significantly more detail with the ultimate aim of making sense of government complexity, results of (Mean=4.05, SD=1.02) were obtained with 38(31.7%) disagreed, 35(29.2%) agreed, 32(26.7%) strongly agreed 10(8.3%) were not sure and 5(4.2%) strongly disagreed. This means that majority of respondents disagreed. The implication of this is that Policy tools analyzes a range of

government tools in significantly more detail with the ultimate aim of making sense of government complexity.

4.4 Challenges faced in the collection of data for health policy formulation in Uganda.

Table 9: **Challenges faced in the collection of data for health policy formulation in Uganda**

Particular	**SD**	**D**	**NS**	**A**	**SA**	$\overline{X}$	**Std.Dev**
Policy-making process tends to be very complex making it difficult for almost anyone to understand it completely	25 (20.8%)	16 (13.3%)	14 (11.7%)	41 (34.2%)	24 (20%)	4.19	0.445
Understanding the process can help empower individuals and community-based organizations to impact policy	14 (11.7%	34 (28.3%)	9 (7.5%)	44 (36.7%)	19 (15.8 %)	3.17	0.318
Many rural communities tend to lack one or more of these resources, a situation which interferes with their ability to effectively impact the policy-making process	20 (16.7%)	23 (19.2%)	6 (5.0%)	36 (30%)	35 (29.2 %)	3.36	0.488
Having inadequate resources negatively impacts a rural community's ability to effectively influence and develop policy compared to other players in the	6 (5.0%)	20 (16.7%)	4 (3.3%)	43 (35.8%	47 (39.2 %	4.87	0.241

policymaking process							
Lack of access to financial resources necessary to address problems and concerns of rural community's leads to organizations relying on volunteers	20 (18.3%)	21 (17.5%)	10 (8.3%)	45 (37.5%)	22 (18.3 %)	4.10	0.492
Low populations in rural areas can result in the availability of only a small number of volunteers to carry out all the necessary activities demanded by their community organizations	22 (18.3%)	21 (17.5%)	10 (8.3%)	45 (37.5%)	22 (18.3 %)	3.20	0.412
Rural citizens have indicated that they feel there is a lack of access to information about government programs and services	18 (15%)	32 (26.7%)	16(13.%)	36 (30%)	18 (15%)	3.03	0.334
The relationship between rural communities and government is strained by the community perception that governments do not understand rural issues and impose policies and programs.	28 (23.3%	39 (32.5%	11 (9.2%)	37 (30.8%)	5 (4.2%)	2.60	0.267

Source: Primary Data

The researcher asked respondents whether Policy-making process tends to be very complex making it difficult for almost anyone to understand it completely giving results of (Mean=4.19, SD=.445). This means that majority of respondents agreed. Policy-making process tends to be very complex making it difficult for almost anyone to understand it completely with 41(34.2%)

agreed, 25(20.8%) strongly disagreed, 24(20%) strongly agreed, 16 (13.3%) disagreed and 14(11.7%) were not sure. This is in line with Howlett and Ramesh, (2002); who argued that policy-making process can help individuals and community-based organizations decide whether they will become involved in trying to develop or change a policy and, if so, how to best go about it. Unfortunately, the policy-making process tends to be very complex making it difficult for almost anyone to understand it completely.

The findings on whether the understanding the process can help empower individuals and community-based organizations to impact policy with 44 (36.7%) agreed, 34(28.3%) disagreed, 19(15.8%) agreed, 14(11.7%) strongly disagreed and 9(7.5%) were nor sure and (Mean=3.17, SD=.318) were obtained. This is consultation with Weible and Sabatier, 2008 who said that understanding the process can help empower individuals and community-based organizations to impact policy. This means that more than average respondents disagreed.

The study also wanted to find out whether many rural communities tend to lack one or more of these resources, a situation which interferes with their ability to effectively impact the policy-making process and results of (Mean=3.36, SD=.488) was acquired where 36(30%) agreed, 35(29.2%) strongly agreed, 23(19.2%) disagreed, 20(16.7%) strongly disagreed and 6(5.0%) were not sure. This was however supported by Howlett (2009) who argued that many rural communities tend to lack one or more of these resources, a situation which interferes with their ability to effectively impact the policy-making process and having inadequate resources negatively impacts a rural community's ability to effectively influence and develop policy compared to other players in the policymaking process.

Respondents were also asked whether Having inadequate resources negatively impacts a rural community's ability to effectively influence and develop policy compared to other players in the policymaking process whereby 47 (35.8%) agreed, 47 (39.2%) strongly agreed, 20(16.7%) disagreed, 6(5.0%) strongly disagreed and 4(3.3%) were not sure and (Mean=4.87, SD=.241) were obtained.

The information on whether Lack of access to financial resources necessary to address problems and concerns of rural community's leads to organizations relying on volunteers revealed that

45(37.5%) agreed, 22 (18.3%) strongly agreed, 21 (17.5%) disagreed, 20 (16.7%) strongly disagreed, 10 (8.3%) were not and results of (Mean=4.10, SD=.492) were obtained. This mean that majority of respondents agreed. This implies that Lack of access to financial resources necessary to address problems and concerns of rural community's leads to organizations relying on volunteers.

On the other hand, respondents were asked whether Low populations in rural areas can result in the availability of only a small number of volunteers to carry out all the necessary activities demanded by their community organizations and results of (Mean=3.20, SD=.412) were obtained. This means that more than average respondents disagree.

On whether rural citizens have indicated that they feel there is a lack of access to information about government programs and services whereby 36 (30%) agreed, 32(26.7%) disagreed, 18(15%) strongly agreed, 18(15%) disagreed and 16(13%) were not sure and results of (Mean=3.03, SD=.334) were obtained. This means that more than average respondents disagreed. This implies that rural citizens have indicated that they feel there is a lack of access to information about government programs and services.

CHAPTER FIVE

SUMMARY OF FINDINGS CONCLUSION, RECOMMENDATIONS

5.0 Introduction

This chapter presents a summary of the main findings of the study, conclusions and recommendations and areas that call for further research.

5.1 Summary of findings

The findings on the sources of data for health policy formulation revealed that policy makers say they are able to obtain the data they need and are reasonably satisfied with the current situation , the results obtained consisted a 50(41.7%) agreeing, improving the welfare of people residing in Uganda the improvement of population health, the results with 35(29.2%) agreed, Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves and the results of 46(38.3%) agreed, Administrators, business executives, and non-profit leaders require convenient access to accurate, timely data and analysis concerning the state, revealed that 38(31.7%) of respondents disagreed , primary sources of data are the Uganda department of workforce development 42 (35%) agreed, Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves by 35(29%) who disagreed with 42(35%) strongly agreed Data help in managing businesses, social services, and public activities and Data and analysis should serve to inform discussion about policy alternatives, to monitor progress toward strategic goals and results of 40(48%) agreed.

The study found out that the nature of health policy formulation revealed that policy formulation is the part of the process by which proposed actions are articulated, debated with 60(50%) agreed, Policy formulation involves developing strategies for dealing with policy issues which have been placed on an agenda, where 58(48%) agreed, Policies can be understood as political, management, financial, and administrative mechanisms arranged to reach explicit goals with 61(50.8%) agreed ,Transparency, quality and effectiveness of policies are well established the legitimacy for health policy with 60(50%) strongly agreed, Socio-economic and political conditions of a country determine or shape the network of a particular policy and Policy design theorists given that the

causal chain is the main cause of policies success or failure because the policy designs contribute to policy outcomes with 38(31.7%) disagreed.

The findings on the challenges faced during the health policy formulation revealed that Policy-making process tends to be very complex making it difficult for almost anyone to understand it completely with 41(34.2%) agreed, understanding the process can help empower individuals and community-based organizations to impact policy with 44 (36.7%) agreed, many rural communities tend to lack one or more of these resources, a situation which interferes with their ability to effectively impact the policy-making process where 36(30%) agreed, Having inadequate resources negatively impacts a rural community's ability to effectively influence and develop policy compared to other players in the policymaking process whereby 47 (35.8%) agreed, Lack of access to financial resources necessary to address problems and concerns of rural community's leads to organizations relying on volunteers revealed that 45(37.5%) agreed, Low populations in rural areas can result in the availability of only a small number of volunteers to carry out all the necessary activities demanded by their community organizations and rural citizens have indicated that they feel there is a lack of access to information about government programs and services whereby 36 (30%) agreed.

5.2 Conclusions

On the analysis of health policy formulation revealed that different disciplines and theories, helps the reader to understand the role of actors, as well as of political, economic and contextual factors in shaping policies and strategies that directly affect how a particular health system performs. The importance of understanding the processes through which policies are developed and implemented is discussed. Real-life examples illustrate the difficulties and intricacies of analyzing the health policy process, at the same time pointing to issues that are relevant in an emergency context, such as the role and influence of international agencies and institutions in the policy arena. the policy communities indicated a policy process in which organized interests and governmental actors play a major role in shaping the direction and outcome of health policies and the discourse communities of the dominant idea set always decided the structure of the policy communities. Discourse communities share common level of understanding of a problem,

its definition, and its causes. During the discourse, taking dominant idea set employing a view of culture as a communicative phenomenon involving discursive engagement, which is deeply influenced by social and economic inequalities.

On the analyses of sources of data for health policy formulation, it was discovered that public policy makers and administrators, business executives, and non-profit leaders require convenient access to accurate, timely data and analysis concerning the state, its communities, its citizens, and its economy to carry out their responsibilities properly. Some leaders feel that information they need is not available or is difficult to find or use. As a result, they have problems determining if public initiatives are effective, comparing Uganda 's progress against other states, and clarifying strategic gaps that the state should address.

On the analysis of the challenges facing health policy formulation in Uganda revealed that Government and policy makers are beginning to recognize the important role communities can play in policy development and efforts are being made to allow them to become more involved in the policy-making process. However, despite these efforts, there are still many barriers and challenges that can stand in the way of community involvement. Understanding and anticipating these barriers and challenges is important when a community is getting organized for or involved in policy activity. This understanding can help individuals and organizations more effectively impact the policy-making process. Further, it is important for communities to understand that government also faces barriers and challenges that can hinder its progress in responding to and recognizing the priorities of rural area. Overcoming the barriers and challenges to policy development faced by both rural communities and government will serve to facilitate the policy-making process.

5.3 Recommendations

From the above findings and conclusion, the followings measures are recommended

The government of Uganda should put up the team that of data collectors that will help on improving the level of health most especially on how to avoid jiggers in Busoga Region.

Establish as state policy that, to the extent practical, all Uganda public data should be accessible through the Internet. While this would be impossible to implement totally, it is important that the state establish a strong commitment to maximize the web-accessibility of public information. This policy should also be encouraged among local government and non-government data producers.

In order to move from the current antiquated system to an environment in which the information necessary for policy makers and managers to make informed decisions is being produced and is easily accessible, the Governor and the Legislature should work together and with others to establish a State Data Initiative that will develop an overall vision for data collection, analysis, and dissemination in the state of Uganda, develop a plan for implementing the Initiative; confirm and prioritize the data needs of the state; improve the quality, quantity, and usability of data being produced by and for state government and other stakeholders; provide for the interpretation and analysis of that data; and facilitate the dissemination of the data and analysis.

Designate or establish an organization to implement and manage the State Data Initiative**.** This organization would have the overall responsibility for implementing and managing the Initiative. Its levels of activity would be greater during the planning and implementation phases, but there would be a continuing oversight and coordination role for the organization.

Designate or develop a clearinghouse/resource center for Uganda data and data analyses. As part of its responsibilities, this unit would actively search out all sources of data and analyses and publicize their existence. To improve awareness, the clearinghouse should incorporate this information into a comprehensive directory or guide to Uganda data that would include not only directory information but also discussion of the characteristics/limitations of the data, how to use the information

Awareness could further be enhanced if the clearinghouse were also given the responsibility for providing training activities for policy makers and other data users

incorporating the kinds of information included in the data guide. To improve access, this clearinghouse should establish and maintain a single portal to provide access to all Uganda data on the Web. A link to this portal should be prominently displayed on *access* and other appropriate websites. This single portal would not have to be associated with the development of a single centralized database. It could be constructed with direct links to data.

Other kinds of data that policy makers said that they want for Uganda also do not exist in other states due to a lack of appropriate methodology or the prohibitive cost of collecting the data. But some kinds of data not available in Uganda are available in other states, and methodologies used elsewhere could be adapted for Uganda**.**

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QUESTIONNAIRE

Dear Respondent,

I am Murekye Jean Mugisha, a student of Uganda Martyrs' University Nkozi pursuing Bachelors degree of Science in General Statistics and Economics. I am collecting data for my dissertation Data on Effective Health Policy Formulation in Busoga Region.

The study is purely academic and all data provided shall be treated with confidentiality.

SECTION A: BACKGROUND (Tick on the most appropriate)

1) State your current area of operation at the district

Internal Audit	
Finance and Human Resource	
Clinic	
Laboratory	
Data	
Research and Development	
Operations	

2) State your title in the area

Chairman	Treasury	Vice chairman	Secretary

3) **Gender:** Male ☐ Female ☐

4) **Marital status:** Single ☐ Married ☐ Widow ☐ Widower ☐

5**) Age**

18-24yrs	25-31yrs	32-38yrs	39-45yrs	46-52yrs	Above 52yrs

6) **Academic qualification**

Certificate	Ordinary Diploma	Bachelor's Degree	Post Graduate Diploma	Master's Degree	PhD

7) Years of service in the area

Less than 1 yr	1-4 yrs	5-9 yrs	Above 10 years

INSTRUCTIONS

Indicate the extent to which you agree and disagree with the statements on the items in each of the section by ticking **(√)** the appropriate number listed in the tables.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1	**2**	**3**	**4**	**5**

SECTION B: DATA COLLECTION IN THE FORMULATION OF HEALTH POLICIES

1 = Strongly Disagree, **2** = Disagree, **3** = Not Sure, **4** = Agree, **5** = Strongly Agree

	ITEMS	**SCORES**				
01	Some policy makers say they are able to obtain the data they need and are reasonably satisfied with the current situation	1	2	3	4	5
02	One major way of improving the welfare of people residing in Uganda, is through the improvement of population health	1	2	3	4	5
03	Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves	1	2	3	4	5
04	Administrators, business executives, and non-profit leaders require convenient access to accurate, timely data and analysis concerning the state	1	2	3	4	5
05	The primary sources of data are the Uganda Department of Workforce Development	1	2	3	4	5
06	Policy makers want to receive an interpretation or analysis of the data rather than to examine the data themselves	1	2	3	4	5
07	Data and analysis should serve to inform discussion about policy alternatives, to monitor progress toward strategic goals					
08	Data help in managing businesses, social services, and public activities	1	2	3	4	5
09	State agency responsible for producing employment, unemployment, wage, and other labor market information	1	2	3	4	5

SECTION C: DATA FOR HEALTH POLICY FORMULATION PROCESS IS COLLECTED IN UGANDA

	ITEMS	SCORES				
01	Policy formulation is the part of the process by which proposed actions are articulated, debated	1	2	3	4	5
02	Policy formulation involves developing strategies for dealing with policy issues which have been placed on an agenda	1	2	3	4	5
03	Policies can be understood as political, management, financial, and administrative mechanisms arranged to reach explicit goals.	1	2	3	4	5
04	The information is well established for health policy formation	1	2	3	4	5
05	Socio-economic and political conditions of a country determine or shape the network of a particular policy.	1	2	3	4	5
06	Policy tools analyzes a range of government tools in significantly more detail with the ultimate aim of making sense of government complexity	1	2	3	4	5
07	Policy communities play critical roles in health policy processes	1	2	3	4	5
08	The networks can help as evidence to influence policy processes	1	2	3	4	5

SECTION D: CHALLENGES FACED IN THE COLLECTION OF DATA FOR HEALTH POLICY FORMULATION IN UGANDA.

	Item	SCORES				
01	Policy-making process tends to be very complex making it difficult for almost anyone to understand it completely	1	2	3	4	5
02	Understanding the process can help empower individuals and community-based organizations to impact policy.	1	2	3	4	5
03	Many rural communities tend to lack one or more of these resources, a situation which interferes with their ability to effectively impact the policy-making process	1	2	3	4	5

04	Having inadequate resources negatively impacts a rural community's ability to effectively influence and develop policy compared to other players in the policymaking process	1	2	3	4	5
05	Lack of access to financial resources necessary to address problems and concerns of rural community's leads to organizations relying on volunteers	1	2	3	4	5
06	Low populations in rural areas can result in the availability of only a small number of volunteers to carry out all the necessary activities demanded by their community organizations	1	2	3	4	5
07	Rural citizens have indicated that they feel there is a lack of access to information about government programs and services	1	2	3	4	5
08	The relationship between rural communities and government is strained by the community perception that governments do not understand rural issues and impose policies and programs.	1	2	3	4	5

Thank you so much for your participation!